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ABSTRACT

This Rhode Island KIDS COUNT issue brief, one of a series presenting an in-depth look at issues affecting the health, safety, education, and economic well-being of children, focuses on children's mental health services in the state. The brief reports that mental health services for children in Rhode Island are fragmented, with inadequate capacity and a lack of resources invested in prevention, resulting in postponed care, school failure, costly hospitalization, and juvenile detention. Highlighted in the issue brief are key prevention/early intervention recommendations, including fostering family-centered care, focusing on schools as opportunities for prevention, identification, intervention, and early treatment of mental health issues; reaching young children early by capitalizing on contacts with child care, Head Start, and early intervention programs; focusing prevention resources on children who are especially at-risk, such as those in poverty or in the child welfare system, children with developmental disabilities, and children in homes with substance abuse and violence. The brief recommends increased capacity at all levels of treatment, the creation of respite and family support services for families of children with serious emotional disturbances, and resolution of workforce issues that result in a dearth of mental health professionals. The issue brief concludes with lists of state departmental resources and resources for families. (Contains 43 references.) (KB)

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Issue Brief

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Rhode Island KIDS COUNT

CHILDREN'S MENTAL HEALTH SERVICES IN RHODE ISLAND

Healthy social and emotional development is critical to children's learning, behavior, health, and overall quality of life. Mental health in childhood and adolescence is defined by the U.S. Surgeon General as the "achievement of expected developmental, cognitive, social and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills."[1]

The mental health status of children directly influences their behavior at home and at child care or school, their academic performance, and their ability to participate in community life. While nationally the mental health needs of children are increasing, access to behavioral health, mental health, and substance abuse treatment is decreasing.[2]

Nationally and in Rhode Island, there is an inadequate system of preventive services and supports for children and families at risk. In addition, there is an inadequate system of specialized services for children with diagnosed mental illness or other special mental health needs. Inadequate attention to prevention, the lack of qualified mental health professionals, and the fragmentation of services frequently result in postponed care, school failure, costly hospitalization, and juvenile detention.[3,4,5]

A growing body of research and practice indicates that a comprehensive mental health system for children is one that:

- Promotes **healthy mental and socio-emotional development for all children beginning in the early years.**
- Expands the skills of parents, teachers, and other caregivers who nurture and support infants, children and teens.
- Ensures **screening and assessment** to identify problems early and targets prevention and early intervention services to those **children who are most at risk.**
- Provides a **continuum of treatment** opportunities and interventions for children with identified mental health problems or disorders, as well as **support systems for families of these children.**[6,7]

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AGENCIES RESPONSIBLE FOR MENTAL HEALTH

The Department of Children, Youth and Families (DCYF) is the agency in Rhode Island with statutory responsibility for mental health services for children. DCYF provides direct services for children in its custody. It also contracts with community-based agencies to provide outpatient services to children throughout Rhode Island and administers a number of specialized behavioral health programs.

The Department of Human Services (DHS) administers the state Medicaid program, which funds a broad range of mental health services (without limits on days of service, subject only to medical necessity).

The Department of Health administers the Early Intervention Program in Rhode Island, oversees School-Based Health Centers and administers a number of community-based health promotion programs for youth and families.

The Department of Elementary and Secondary Education is responsible for the oversight of Local Education Agencies (school districts) that locate, identify, and provide special education and related services to any child ages 3 to 21 with a disability.

The Department of Mental Health, Retardation and Hospitals (MHRH) is responsible for the oversight and licensing of Community Mental Health Centers and for the licensing of hospitals as psychiatric facilities. It operates the state's long-term psychiatric inpatient unit and oversees the systems for adults with serious mental illness. It is also responsible for substance abuse prevention and treatment programs that serve adults, children and youth.

MENTAL HEALTH FOR CHILDREN OF ALL AGES

Mental health and mental illness are points on a continuum. Just as children are rarely completely physically healthy or unhealthy, children may experience mental health problems of varying levels of intensity, severity, and impact throughout the course of their lives.[8]

Key factors in promoting universal mental health for children include public awareness of the social and emotional health needs of all children, access to the economic, educational, social and health supports families need to thrive, easy access to appropriate services when mental health issues arise, and eliminating the stigma associated with mental illness.[9]

Young Children

Healthy development begins before birth. Primary health providers are in an important position to screen for risk factors during pregnancy, particularly for maternal depression, substance abuse or domestic violence. Pediatricians are better able to address mental health concerns when their training includes how to screen for maternal mental health and age-appropriate infant and toddler development. Child care providers and other early care and education professionals provide higher quality care when they have training in infant-child development and access to mental health consultation. Children are less likely to develop delays in social and emotional development when families with identified risk factors are connected to comprehensive, intensive services that provide a combination of family support, services needed by the parent, child development services, and attention to basic needs.[10,11,12]

School-Age Children and Adolescents

Children who are struggling socially or academically in school may be experiencing mental, emotional, behavioral or learning problems. As children reach adolescence, additional pressures and stressors come into play. The most effective school-based supports include training for school staff to monitor student academic and social performance, identify and address emotional and mental health problems, provide assessment, referral and individualized support at the first signs of difficulty, and offer school-based physical and mental health services. In addition to the primary role of school staff, other key supports for healthy social and emotional development include after-school programs, community-based recreation programs, and specialized supports such as substance abuse treatment and teen health services.[13,14]

CHILDREN AT RISK: IDENTIFICATION AND INTERVENTION

"Children and families are suffering because of missed opportunities for prevention and early identification, fragmented services, and low priorities for resources. Overriding these problems is the issue of stigma, which continues to surround mental illness."[15]

Risk factors for mental and emotional problems or mental illnesses in children include biological factors (such as prematurity, low birthweight, inherited propensities, trauma, and exposure to toxins - e.g. lead) and psychosocial factors (such as the child's economic, neighborhood and family circumstances).[16,17]

Children in Poverty. Poverty is a critical risk factor associated with developmental and mental health problems in children. Economic hardship can cause stresses which impact parenting, increase rates of child maltreatment and maternal depression, and affect the child's emotional development; it can also affect the quality of health care, nutrition, child care and education available to a family. This combination of circumstances affects all aspects of child development.[18,19] In Rhode Island, 16.5% of children live in poverty.[20]

Minority and Immigrant Children. In the United States, minority children and adults are less likely to receive quality mental health services. At the same time they are more likely to experience poverty, racism, discrimination, and violence, all of which take their toll on mental health. Immigrant children who were exposed to violence in their native country may suffer post-traumatic stress disorder. Barriers to services include lack of trust and lack of linguistically and culturally-appropriate services. In some cultures, there is a particularly high stigma associated with mental illness.[21,22] In Rhode Island, 27% or 67,747 children are from racial or ethnic minority groups.[23]

Children with Developmental Disabilities. Mental, emotional, behavioral or psychiatric disorders in individuals with mental retardation or developmental disabilities are 3 to 4 times more likely than in the general population, but are less likely to be appropriately diagnosed and treated. Individuals with developmental disabilities are frequently excluded from research studies, resulting in limited knowledge about and access to appropriate treatment.[24]

Children in Families Affected by Mental Illness, Domestic Violence and Substance Abuse. Children in families affected by mental illness, domestic violence and substance abuse are more likely than other children to exhibit attachment disorders, behavioral problems and disorders, and developmental delays. As adolescents they are especially vulnerable to substance abuse problems and other high-risk behaviors. Using adult-focused welfare, substance abuse, domestic violence and mental health services as points of entry to intensive and early family and child focused services can improve outcomes for these highly vulnerable children.[25,26]

Children in the Child Welfare and Juvenile Justice Systems. Children in the child welfare and juvenile justice systems are far more likely to experience physical, mental, behavioral, emotional and substance abuse problems than children in the general population.[27] Children in out-of-home placement due to child abuse and neglect and youth at the Training School benefit from early and comprehensive screening, a continuum of individualized services, and monitoring to ensure service provision. Preventive services are needed to support families with children at risk of out-of-home placement.[28]

There is increasing recognition that mental disorders, whether arising from biological or psycho-social causes or both, affect the physical function of the brain, and are treatable. There is "no scientific basis for distinguishing between mental illness and other forms of illness...mental disorders are physical disorders."[29]

CHILDREN WITH IDENTIFIED MENTAL HEALTH PROBLEMS

THE IMPACT OF INADEQUATE MENTAL HEALTH SERVICES

Nationally, more than 80% of all children and youth with some mental health problem do not receive any treatment.[30] Inadequate care has negative impacts on children and is reflected in rising juvenile suicide and incarceration rates. The toll on families is devastating.[31]

In the United States, one in five children ages 9-17 has a diagnosable mental, behavioral, or addictive disorder. One in ten suffers severe functional impairment as a result of a disorder. Untreated mental health problems can have severe, long-term consequences on a child's well-being and future potential. [32,33]

A national survey of caregivers of children with serious mental health problems indicates the inadequacy of mental health service delivery systems. The majority of respondents (56%) indicate that their child's primary care physician had failed to recognize their child's serious mental illness. Managed care limits or denies needed services (49% of respondents) and lack of health insurance parity affects access to mental health services (66%). Schools do not act quickly to evaluate and provide appropriate placements (72%) and school staff are not trained to deal with mental health issues (81%). Twenty percent of respondents were forced to relinquish custody of children to get treatment. Fifty percent worry their child will become violent due to lack of treatment or feel blamed for the child's condition. To care for the ill child one parent had to change jobs or quit work in over half (55%) of responding families. Families feel pushed to the breaking point (59%), marriages are severely stressed by the child's mental illness (70%) and siblings are negatively affected (80%).[34]

The experiences of Rhode Island families parallel those of national survey respondents: more than any other group of caregivers of children with disabilities, the caregivers of mentally ill children are likely to feel overwhelmed, in need of assistance, and without adequate supports or respite.[35]

THE TOLL ON FAMILIES WITH MENTALLY ILL CHILDREN IN RHODE ISLAND

% of Caregivers of Mentally Ill* Children on Medicaid Who Are:	
Not able to get support from family and friends	52%
Unable to work due to caretaking responsibility	54%
Feel overwhelmed due to their child's needs	83%

% of Caregivers of Mentally Ill Children on Medicaid Who Need Services and Who Find Service Unavailable or Does Not Meet Child's Needs	
Mental health counseling	48%
Child care	74%
Information on primary condition	81%
Parent support groups	87%
Parent education class	99%
Respite care	99%

*Mental illness in this survey is defined as anxiety, manic depression/psychosis, schizophrenia, post-traumatic stress, attention deficit disorder, and emotional/behavioral problems.

Source: Griffin, J. (1998). *Health Care Needs of Children with Disabilities on Medicaid: Results of Caregiver Survey.* MCH Evaluation, Inc. and Special Analysis of Data from the Medicaid Data Archive.

ELEMENTS OF AN EFFECTIVE MENTAL HEALTH SYSTEM FOR CHILDREN

Addressing the needs of children and families with identified emotional/mental health problems requires a system of service delivery which offers an integrated continuum of care. An effective mental health system for children ensures that:

- **There is an integrated continuum of multiple and diverse services and supports for children and families, and there is adequate capacity and access to services at all levels of need.** The full range of prevention, assessment, treatment, and family support programs is necessary. The system is prevention-focused rather than crisis-driven.[36,37]
- **Services are family-centered and culturally and linguistically competent. Families are included in both individualized service planning and policy development.** Services are coordinated, strength-based, individualized, and provided in natural environments, such as homes, schools, child care centers, and community organizations.[38] Culturally-competent providers are recruited and trained.[39]
- **Frontline service providers such as educators, child care providers, and pediatricians are adequately trained.** They are able to recognize potential signs of mental, emotional and developmental problems and to work with specialized professionals to assess, diagnose and address them.[40,41]
- **There are adequate numbers of qualified child mental health professionals (particularly those experienced working with young children) and developmental/behavioral pediatricians.** Factors that promote the quality and sufficiency of the workforce include training, adequate compensation rates, and manageable administrative and regulatory systems.[42,43]
- **A seamless and cost-effective service delivery system is achieved through effective collaboration among all agencies involved and through coordinated funding streams.** Rather than being programmatic and categorical, funding is sufficiently flexible to meet individualized needs of children and families.[44]
- **The system is adequately financed.** Insurance parity legislation, adequate reimbursement rates, creative leveraging of private and federal funds, and a commitment of state resources may be required.[45,46]
- **Accountability and quality are ensured** through ongoing evaluation and reliance on evidence-based treatment, best-practices, up-to-date research and standards of care.[47]

DESIGNING A COLLABORATIVE SYSTEM OF CARE

Two recent Rhode Island reports highlight key principles and strategies to create an adequately-funded continuum of prevention and treatment services for children and youth.

According to the Rhode Island Public Expenditure Council's January 2001 *Review of the Department of Children Youth and Families*, a disproportionate share of the DCYF budget continues to be spent on high-end costs such as psychiatric hospitalizations, juvenile corrections, and residential treatment rather than in prevention programs for vulnerable families, community-based placements and outpatient services. This report was commissioned by the Children's Policy Coalition, a group of more than 30 advocacy, human services agencies and individuals concerned with issues affecting children and families in the care of DCYF.[48]

In October of 2002, the Rhode Island System of Care Task Force – a group of legislators, state agency leaders, advocates, and service providers – released a report outlining a plan to create an "organized system of care" in Rhode Island that provides all families and primary caregivers with ready access to the resources necessary to meet their child's developmental needs. The report proposes mechanisms to achieve cost savings by reducing reliance on restrictive and expensive placements and increasing investments in community-based prevention and intervention services. The recommendations in the report, *Toward an Organized System of Care for Rhode Island's Children Youth and Families*, will be implemented under the guidance of an Implementation Committee and a set of benchmarks to measure progress.[49]

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MENTAL HEALTH STRATEGIES IN CHILD CARE SETTINGS

The overall aim of early childhood mental health strategies is to help children acquire age-appropriate social skills and behavior. Early experiences set the stage for how children relate to other children, how they relate to adults, how they manage anger, and how they feel about themselves.[50]

Several efforts in Rhode Island include components designed to enhance the skills of caregivers who nurture and support young children:

Comprehensive Child Care Networks are modeled on the comprehensive education, health, and mental health services established and defined in the Head Start program. One component of the Comprehensive Child Care Networks enables child care, family child care, and Head Start providers to more easily access mental health consultation for staff, children and parents. There are currently four networks serving up to 450 children.[51]

The Child Care Support Network administered by the RI Department of Health provides on-site technical assistance for licensed child care providers, including assistance with children's behavioral problems. Currently 22 centers and 45 family homes receive support through the program.[52]

The Providence Center's Early Childhood Program recently received a federal grant to provide child care and other services to children with behavioral disorders and to train providers to support the special needs of these children and their families.[53]

YOUNG CHILDREN IN THE MOST VULNERABLE FAMILIES

Poverty, isolation, the lack of a support network and other factors place many infants and young children at risk for poor developmental outcomes. For some families, the added problems of domestic violence, community violence, substance abuse and maternal depression compromise child development with long-term consequences.[54]

Targeted resources are needed to link the most at-risk pregnant women and new parents to comprehensive programs that can work with them intensively and over time. Promising strategies include Early Head Start and Project Connect.

Early Head Start provides supports to vulnerable families during pregnancy, provides child development services and supports healthy family functioning. A national evaluation of this program points to improvements in child outcomes for those programs that are implemented according to quality standards.[55]

Federal funding supports five Early Head Start programs in Rhode Island serving approximately 400 children. This is a small fraction of the children and families that would benefit from this comprehensive intensive program for vulnerable young children.[56]

Project Connect at Children's Friend and Service provides intensive, home-based services to families that are involved with DCYF and have an identified substance abuse problem. Families recieve intensive individualized services and staff are specially trained in substance abuse and child welfare issues.

CHILDREN IN THE CARE OF DCYF

Children in out-of-home care frequently suffer from serious developmental and psychological problems. Effective strategies to promote the optimal development of children in out-of-home placement include:[57]

- Comprehensive assessment of each child's needs at system entry.
- A process to address behavioral health needs immediately.
- Monitoring to ensure appropriate services are provided.
- For young children, enrollment in a high quality early care and education program.

SCHOOLS AS OPPORTUNITIES FOR PREVENTION, EARLY INTERVENTION AND TREATMENT

Research and best practices indicate that school reform focused exclusively on improving instruction, administrative practices, and governance will fail to achieve desired academic improvements unless addressing barriers to development and learning is included as an equal and essential component of reform.[58]

There is increasing recognition that in order to succeed in educating all children, schools must begin to focus on a comprehensive continuum of services which: 1) address barriers to learning; 2) include prevention strategies, intervene early to address problems at onset, and provide treatment for severe and chronic problems; 3) are well-integrated with each other, with community services and with the school's educational programming; and 4) are given equal importance with the more traditional educational components of instruction and administration.[59]

By virtue of their daily contact with most children between the ages of 5 and 18 (and some children with special needs between ages 3 and 21), schools offer unique opportunities to address the emotional, behavioral, psychosocial and mental health needs of children before they interfere with learning, require referral for special education or reach crisis proportions.

Both nationally and in Rhode Island, most schools have only dealt with these issues in fragmented, narrow and specialized ways, providing limited services to the most severely disturbed children who qualify for special education due to a diagnosed Severe Emotional Disturbance (SED), or offering project-based initiatives disconnected from other programming and vulnerable to the vagaries of uncertain or time-limited funding. Even these limited supports and staff are often seen as auxiliary, are marginalized and not included in overall planning, and, except where explicitly mandated by law, are the first to be targeted for reduction whenever resources are scarce.[60]

THE MENTAL HEALTH AND WELLNESS INITIATIVE AT HOPE HIGH SCHOOL

Hope High School is the recipient of a three-year, $500,000 award from Health & Education Leadership for Providence to create a model integrated student support system that includes school professionals and the mental health community. The initiative is designed to address the barriers that keep students from academic achievement and social-emotional wellness. The intent is to provide a continuum of support to all students who need guidance, intervention, or treatment. The school is partnering with mental health resources at Rhode Island Hospital, Bradley Hospital, and Brown Medical School. There is focused attention on how to replicate and sustain the model as part of the Providence School Department's high school redesign process.[61]

SPECIAL EDUCATION IN RHODE ISLAND: THE PROMISE OF EARLY IDENTIFICATION AND SERVICES

A recent report commissioned by the Rhode Island General Assembly recommends increased attention and resources focused on prevention, early identification and treatment, as a means to preventing later, costlier and less-appropriate special education services. The report warns that "special education cost containment should not occur at the expense of children who require early identification and intervention programs." In addition, if the increase in the numbers of children needing special education services today is to be addressed, "the capacity to provide research-based intensive instructional programs at the primary and intermediate levels for all children who perform at unacceptably low academic levels must be expanded."

Source: *Children with Disabilities Study: Special Education in the Context of School Reform*, Commissioned by the Rhode Island General Assembly in July of 1999 (released September, 2002).

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FAMILY-CENTERED CARE IN RHODE ISLAND

As is true nationally, the mental health system in Rhode Island is fragmented, with multiple agencies, providers and funding streams.

Two efforts to assist families in coordinating services are:

The Child and Adolescent Service System Program. CASSP is a DCYF program managed by local Community Mental Health Centers. CASSP works with children with serious emotional, behavioral or mental disorders in order to provide comprehensive and community-based services, including recreational and family support services. LCCs (Local Coordinating Councils) made up of representatives of various agencies, advocacy groups and parents are responsible for coordinating a continuum of services. Project HOPE, an extension of CASSP, provides case management support for youth transitioning from the Rhode Island Training School to the community.[62]

Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation. CEDARR is a recent initiative under the leadership of DHS, the state Medicaid agency, intended to serve as a one-stop source of clinical information, evaluation, and connection to community supports and assistance for families with children with special needs. There are currently four CEDARRs with an enrollment of 500 families.[63]

THE CURRENT SYSTEM OF CARE IN RHODE ISLAND

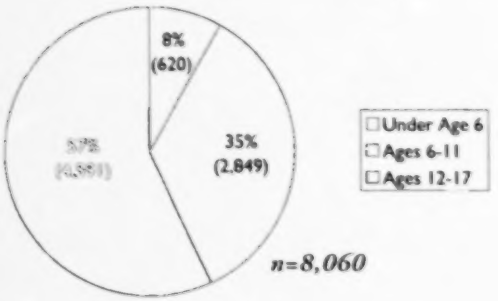
"We rely on out-of-state and out-of-home placements in part because we lack less restrictive prevention, early intervention and treatment alternatives for the many [Rhode Island] children who are in need of mental health services." [64]

OUTPATIENT SERVICES

Private practitioners, such as child psychologists, child psychiatrists, and licensed clinical social workers are an important source of mental health services for children in Rhode Island.

In addition, there are eight community mental health centers in Rhode Island. The centers are an important source of outpatient public mental health treatment services for children and adults.

Children's Services at Community Mental Health Centers (CMHCs), Rhode Island, December 1, 2000 – November 30, 2001



- The largest percentage of children served were between the ages of 12 and 17.
- Sixty-one percent of children served in 2001 were male; 53% were White, 11% Hispanic, 8% Black, and 28% were "other or unknown" race/ethnicity.
- In 2001, 45% of mental health services for children at community mental health centers were paid for by Medicaid /RIte Care, 26% by Commercial Insurance, and 30% from other sources.*

*Data regarding payment source often reflect status at time of intake and may change throughout the course of the year.

Source: Rhode Island Department of Mental Health, Retardation and Hospitals, January 2002

CHILDREN IN DCYF CUSTODY OR RESIDENTIAL CARE

DCYF is responsible for developing public policy and programs that ensure access for all children in Rhode Island who need mental health / behavioral health services (including direct services for children in DCYF custody). In FY 2001, just over half of the 3,304 children in DCYF out-of-home placement also received mental health services. Of the 1,787 children in out-of-home placement who received mental health services, 146 also received substance abuse treatment and 279 were in psychiatric hospital placement. DCYF contracts for the services of a variety of residential programs for children and youth, all of which include a mental health component. Such programs include specialized foster care, mental health and substance abuse treatment, hospital alternatives, shelters and out-of-state programs. Most are consistently at 85% to 100% capacity.[65] The lack of an appropriate continuum of community-based services results in children in DCYF care being placed in temporary night-to-night placement and also affects the ability of hospitalized children to leave the hospital and of children who need intensive interventions to avoid costly hospitalizations.[66]

HOME AND COMMUNITY-BASED SERVICES

Home-Based Therapeutic Services (HBTS). HBTS are provided to children living at home who have been diagnosed with moderate to severe physical, developmental, behavioral or psychiatric conditions. Goals may include achievement of behavioral, self-help, social and other skills. In 2001, 531 children received HBTS. Currently 18 agencies in Rhode Island deliver HBTS. Many have long waiting lists. DHS recently finalized new HBTS performance standards intended to enhance quality. Current and new providers are in the process of being certified.[67]

Children's Intensive Services (CIS). CIS is a program administered by DCYF for children with a serious emotional disturbance who are at risk for hospitalization or out-of-home placement. The program is available to all children who meet the criteria whether or not active with DCYF. A full range of clinical services is available including psychiatric assessment, medication management, home-based therapy, and case management. In 2001, 2,251 children received CIS services. Capacity limits create waiting lists in some parts of the state. DCYF and DHS are currently finalizing levels of care criteria and new certification standards.[68]

Comprehensive Emergency Services (CES) is home-based program for families in crisis, with a focus on prevention of child abuse and out-of-home placement. The program is administered by DCYF and services include referral to mental health professionals. In 2001, an estimated 3,044 children received CES services and approximately 468 of them received specialized mental health services.[69]

Project Early Start is an early intervention program administered by DCYF that focuses on improving parenting skills in disadvantaged families with children up to age 5. In 2001, an estimated 1,199 children received Project Early Start services and approximately 99 of them received specialized mental health services.[70]

SUBSTANCE ABUSE PREVENTION AND TREATMENT

The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH), Division of Behavioral Health Care Services, funds programs for adults and youth with substance abuse problems. Prevention programs target at-risk youth, including those that have dropped out of school, runaways, gang members, and those referred to juvenile hearing boards as a result of drug charges. In addition to prevention services, in fiscal year 2001 MHRH provided substance abuse treatment services to 663 youths. Thirteen percent received treatment in residential programs and 87% in outpatient programs. The three adolescent residential treatment programs in the state are almost always at capacity.

Source: Rhode Island Department of Mental Health, Retardation and Hospitals, 2002.

HOSPITAL-BASED SERVICES

- **Bradley Hospital** is Rhode Island's largest psychiatric center for children. In fiscal year 2001, 860 children were discharged from Bradley Hospital; 6,748 children were seen for outpatient visits; 1,128 emergency evaluations took place; there were 755 crisis appointments; and 12,606 home health visits were provided.[71]
- In 2001, **Butler Hospital** provided 852 hospital admissions and 327 partial hospital or outpatient visits to children. This represents a drop of 20% since 2000 and is primarily due to the closure of satellite outpatient offices.[72]
- At **Rhode Island Hospital**, 7,150 child psychiatry outpatient visits were provided during fiscal year 2001. In addition, the Child Development Center at Rhode Island Hospital conducted 1,012 child evaluations and assisted 1,034 families with children with complex physical, behavioral and/or developmental disorders whom it follows longitudinally.[73]
- **The Neurodevelopmental Center at Memorial Hospital of Rhode Island** evaluates approximately 400 to 425 new child patients per year and follows approximately 1,750 children with complex developmental/behavioral problems. In 2001, approximately 4,800 follow-up visits were provided to these children. There is an extensive waiting list for services at the Center.[74]

OUTPATIENT AND INPATIENT CAPACITY

Limited outpatient capacity results in costly crisis intervention. For instance, Bradley Hospital's outpatient services have decreased during the past three years and are at capacity most of the time; it is estimated that one-third of the evaluations and most of the crisis appointments at Bradley would not have been needed if timely outpatient services had been available.[75]

The shortage of outpatient services also has an impact on hospital inpatient capacity. A conservative estimate is that 400 children, primarily in their early teens, were turned away from inpatient evaluations at Bradley during the past calendar year. When Bradley Hospital beds are full, emergency cases are frequently sent to the Hasbro emergency room (and occasionally to Memorial Hospital of Rhode Island) where they are treated and await a bed opening, typically for 24-48 hours.[76]

SCHOOLS AS PROVIDERS OF MENTAL HEALTH SERVICES

Nationally, the public school system is the sole provider of services for nearly half of all children receiving mental health services.[77]

SPECIAL EDUCATION

In Rhode Island during the 2000-2001 school year, 2,573 children between the ages of 3 and 21 were identified within the special education system as being disabled because of behavioral disorders.[78] Children whose academic performance is not affected are often not classified as disabled and may not be receiving school-based services for their mental health or behavioral needs.

SCHOOL-BASED HEALTH CENTERS

There are seven school-based health centers (SBHCs) in Rhode Island. During the 2000-2001 school year, 2,094 visits to school-based health centers involved behavioral health issues. Student access to mental health providers at SBHCs or through SBHC referrals varies from center to center.[79] Only 5% of Rhode Island public school students have access to SBHCs.[80,81]

REIMBURSEMENT AND WORKFORCE ISSUES: THE IMPACT ON MENTAL HEALTH SERVICES CAPACITY

Nationally and in Rhode Island there is a lack of certified, clinically-active mental health professionals. Mental health professionals include psychologists, social workers, counselors, family therapists, nurse specialists, and substance abuse counselors. The shortage of child and adolescent psychiatrists is particularly acute. Linguistically and culturally appropriate mental health care for children is very difficult to find.[82,83]

Low reimbursement rates are an important factor discouraging mental health practitioners from remaining in Rhode Island and affecting the capacity of the state's mental health care system for children.

There are multiple rates to consider in order to effectively increase service capacity in the mental health field:[84]

- For children enrolled in RIte Care, each of the 12 participating health plans adopts its own rates and negotiates distinct rates with providers.
- Medicaid fee-for-service rates apply to approximately 8,000 children.
- There are different rates for hospitals and for Local Education Agencies (school districts).
- Private health insurance plans negotiate their own rates with providers.

There are some common concerns associated with various rates:[85,86,87]

Child and adolescent psychiatrists and psychologists indicate that both public and private insurance rates do not reflect the 30% to 50% greater time commitment and the differential nature of services associated with evaluating and treating children as compared to adults (e.g., additional visits to assess child or additional time for consultation with parents or teachers). The reimbursement processes are also frequently perceived as burdensome.

As a result, some child psychiatrists turn to treating adults instead of children, or accept salaried administrative or academic positions. This further exacerbates the shortage of child and adolescent psychiatrists. Waiting times of two to three months to see a child psychiatrist are common.

Those child psychiatrists who do treat children frequently do so part-time and may not accept Medicaid or even private insurance.

While nationally recognized university psychiatry and psychology programs in Rhode Island train many highly-qualified professionals, most of them do not choose to remain in Rhode Island.

Efforts that reduce the segregation of primary care services and mental health services can increase system capacity and quality of care by offering coordinated treatment of the whole person (physical health and mental health). Implementing an integrated model of health care requires changes in education and training of health professionals, diagnostic criteria, financing and oversight.[88]

PARITY BETWEEN PHYSICAL HEALTH SERVICES AND MENTAL HEALTH SERVICES

"Parity legislation" is legislation that requires comparability between insurance benefits for physical and mental health services. The special needs of children with mental health issues and appropriate treatment plans for children must also be addressed in insurers' responsibilities. *Rhode Island's 2001 Mental Health and Substance Abuse Parity Legislation* expanded the types of mental illnesses that must be covered by private insurance, the number of therapy visits and array of treatment services (including substance abuse treatment, outpatient, and other treatment) that must be covered. Federal parity legislation, currently pending in Congress, would further expand group health plans' responsibility by prohibiting differential treatment (such as a cap in the number of annual visits) between coverage for mental and physical illness.[89,90]

RECOMMENDATIONS

PREVENTION, EARLY IDENTIFICATION AND EARLY INTERVENTION

Child Care

- **Invest in child care quality enhancement efforts (such as accreditation efforts, provider training and child care rating systems)**, given evidence that high quality child care improves outcomes for children, including those at risk for socio-emotional and behavioral challenges.
- **Expand the capacity of the Comprehensive Child Care Networks and the Child Care Support Network to provide best-practice mental health consultation to child care centers, family child care homes and Head Start** in order to ensure that early care and education environments are high-quality and adequately address the social, emotional and behavioral issues of children.

The Most Vulnerable Children

- **Increase state investments in comprehensive, intensive family support programs for families with young children.** State funding of research-based programs such as Early Head Start, Project Early Start, and Project Connect are cost-effective in the long-term because they provide comprehensive and intensive services to families struggling with substance abuse, instability, and poverty.
- **Ensure that children in the care of DCYF receive the physical health, mental health, education and social support they need to thrive.** Effective strategies to promote development of vulnerable children include assessment of the child's needs at system entry; a process to address physical, mental, emotional, behavioral health and education needs immediately; monitoring mechanisms to ensure services are provided; and, access to quality early education programs and after-school care.

The Foundations for Learning Act, passed in 2001 as part of the reauthorization of the Elementary and Secondary Education Act, provides communities with funding to integrate emotional and social development support services into early childhood programs.

School-Linked Services

Expand the capacity of schools to successfully address the needs of the whole child, including behavioral, emotional and mental health needs.

- **Adopt a new vision of education that includes addressing barriers to learning** as an essential component of reform, along with improving instruction and administration.
- **Invest in a comprehensive, well-coordinated and community-linked continuum of school-based services** that include prevention, early identification and remediation, and intensive services for those with severe or chronic needs.
- Link any potential changes in special education eligibility criteria to **increased resources for early identification and intervention, as well as intensive early-grade literacy and remediation efforts for children who are falling behind.**
- **Provide teacher and school staff training** and support that enables them to help students with social, emotional, or behavioral challenges.
- **Increase the availability of high quality after-school programming,** including the supports needed for children and youth with behavioral challenges to participate successfully in these programs. Provide alternative therapeutic after-school programming for those who need it.

HR 5352: Addressing Children's Mental Health Needs in Schools Through Prevention and Early Intervention

The "Reducing Special Education Through Prevention Act", sponsored by Congressman Patrick Kennedy and announced on September 27, 2002 is intended to provide funds to state and local education agencies to assist in building a continuum of care for the mental health needs of children. If the legislation passes, grants will be targeted towards primary prevention, early intervention, effective coordination of schools with families and mental health providers, and professional development of staff.

Source: Congressman Patrick Kennedy's Press Release, September 27, 2002

RECOMMENDATIONS

EXPAND COMMUNITY TREATMENT CAPACITY TO REDUCE OVER-RELIANCE ON HIGH-END CRISIS CARE

Systems Capacity

Expand treatment capacity to provide a continuum of community and family-centered services that address children's needs at varying levels and that provide for continuity and smooth transition between services.

Identify specific financing mechanisms to fund the community-based services, mobile emergency services, and family respite that are necessary to prevent unnecessary pyschiatric hospitalization and residential placements and/or to transition children and youth back into the community.

Introduce standards and evaluations based on evidence-based treatment, up-to-date research and best practices to monitor quality and outcomes for publicly-funded mental health services. Ensure that there is adequate and informed participation by both consumers and providers of services.

Workforce Issues

Improve training for frontline service providers such as child care providers, teachers, school staff, and pediatricians so they are better able to recognize potential signs of mental, emotional and developmental problems and to work with specialized professionals to assess, diagnose and address them in a collaborative model of care.

Increase reimbursement rates and revise reimbursement codes to reflect the additional time and cost as well as the differential nature of providing mental health services to children. Rates should reflect the nature of services provided and be tied to accountability and quality standards.

Improve the level of cultural competency in the mental health field through improved training of current mental health professionals and the recruitment and training of diverse and multilingual mental health professionals. Statewide leadership by public agencies and educational institutions is necessary.

Respite Care and Support for Families

Develop adequately-financed opportunities for respite care which is identified as unavailable and critically needed by 99% of caregivers of mentally ill children in Rhode Island. Ensure that the respite needs of families are addressed as DHS and DCYF develop new certification standards for CIS and HBTS programs, which have often provided for the respite needs of families in the past.

Expand parent education and advocacy to assist parents in coping with difficult behaviors, special education issues and other challenges of mental illness.

Expand opportunities for family supports specific to the needs of families dealing with mental illness and behavioral challenges. These include parent and sibling counseling and support groups and/or intensive, individualized family services as needed.

Implementation of a High-Quality System of Care

Build on the recommendations of the RIPEC report and the Rhode Island System of Care Task Force report to create a concrete plan to move toward a flexible, coordinated, adequately-financed system of mental health service delivery. Such a system would:

- Strengthen statewide leadership by the legislative, executive, and judicial branches of government to ensure that a concrete plan of action is developed, adequately funded and implemented in a timely manner.
- Increase and formalize interagency collaboration to avoid duplication, reduce gaps in services, and coordinate and maximize funding streams.
- At both a statewide level, and at the level of each provider agency, formalize approaches that promote a family-centered and culturally-competent model of service delivery.
- Increase capacity to use state data and national benchmarks to inform policy, planning and financing.[91]

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RESOURCES FOR FAMILIES

The Rhode Island Parent Information Network. (RIPIN) Training, information, support and advocacy for families and children.
1-800-464-3399, www.ripin.org

Family Voices of Rhode Island. Part of a national network providing information, advocacy, and support for families and friends of children with special health care needs, including chronic illnesses and disabilities.
401-727-4144 www.ripin.org/family and www.familyvoices.org

Parent Support Network.(PSN) A statewide family support organization for families with children who are at-risk or have behavioral/emotional challenges. Support groups, one-to-one advocacy assistance.
401-467-6855 or 800-483-8844

National Alliance for the Mentally Ill - Rhode Island. NAMI-RI provides support to people with mental illness and their friends or family members, educates professionals and the public about mental illness, and advocates for improved services for all people with mental illness.
403-331-3060

CEDARR programs provide evaluation, case management and referral for children with special needs.
About Families: 401-331-2700
Family Solutions: 401-461-4351
Families First: 401-444-7703
Easter Seals: 401-284-1000
CEDARR Family Center Resource Guide (May 2001). Available on-line at: *www.dhs.state.ri.us.*

Rhode Island Disability Law Center, Inc. Free legal assistance for persons with developmental disabilities in areas including education and other services.
401-831-3150 or 800-733-5332

The Office of the Mental Health Advocate. The Office has jurisdiction over all licensed psychiatric facilities, community mental health centers, and licensed mental health group homes. It provides legal counsel to subjects of involuntary psychiatric hospitalization or to clients of the mental health system with concerns over treatment and other rights. *401-462-2003*

Office of the Child Advocate. The Office protects the civil, legal, and special rights of all children involved with DCYF. *401-222-6650*

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